

104TH CONGRESS
1ST SESSION

H. R. 2329

To amend title XVIII of the Social Security Act to provide protections for medicare beneficiaries who enroll in medicare managed care plans.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 14, 1995

Mr. BROWN of Ohio introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to provide protections for medicare beneficiaries who enroll in medicare managed care plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Patient
5 Choice Act of 1995”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

1 (1) There should be no unreasonable barriers or
2 impediments to the ability of individuals enrolled in
3 health care plans to obtain appropriate specialized
4 medical services.

5 (2) The patient's first point of contact in a
6 health care plan must be encouraged to make all ap-
7 propriate medical referrals and should not be con-
8 strained financially from making such referrals.

9 (3) Some health care plans may impede timely
10 access to specialty care.

11 (4) At any time, patients must be able to access
12 out-of-network items, treatment, and services at an
13 additional cost to the patient which is not so prohibi-
14 tive that they are deterred from seeing the health
15 care provider of their own choice.

16 (5) Specialty care must be available for the full
17 duration of the patient's medical needs and not lim-
18 ited by time or number of visits.

19 (6) Direct access to specialty care is essential
20 for patients in emergency and nonemergency situa-
21 tions and for patients with chronic and temporary
22 conditions.

23 **SEC. 3. PROTECTION FOR MEDICARE HMO ENROLLEES.**

24 (a) IN GENERAL.—Section 1876 of the Social Secu-
25 rity Act (42 U.S.C. 1395mm) is amended—

1 (1) in subsection (c)(1), by striking “subsection
2 (e)” and inserting “subsections (e) and (k)”, and
3 (2) by adding at the end the following new sub-
4 section:

5 “(k) BENEFICIARY PROTECTION.—

6 “(1) MINIMUM LOSS RATIO.—

7 “(A) IN GENERAL.—Each eligible organi-
8 zation shall have a loss-ratio that is not less
9 than 85 percent for each contract year.

10 “(B) LOSS RATIO DEFINED.—In subpara-
11 graph (A), the term ‘loss-ratio’ means, with re-
12 spect to an organization for a contract year, the
13 ratio of (i) the anticipated aggregate benefits
14 provided under this section to enrollees for the
15 year, to (ii) the aggregate amount of the pre-
16 miums collected (including payments to the or-
17 ganization under subsection (a) for the year, as
18 estimated on the basis of incurred claims expe-
19 rience and earned premium for the year.

20 “(2) ASSURING ADEQUATE IN-NETWORK AC-
21 CESS.—

22 “(A) TIMELY ACCESS.—An eligible organi-
23 zation that restricts the providers from whom
24 benefits may be obtained must guarantee to en-
25 rollees under this section timely access to pri-

1 mary and specialty health care providers who
2 are appropriate to the enrollee's condition.

3 “(B) ACCESS TO SPECIALIZED CARE.—En-
4 rollees must have access to specialized treat-
5 ment when the treating provider deems nec-
6 essary. This access may be satisfied through
7 contractual arrangements with specialized pro-
8 viders outside of the network.

9 “(C) CONTINUITY OF CARE.—An eligible
10 organization's use of case management may not
11 create an undue burden for enrollees under this
12 section. An organization must ensure direct ac-
13 cess to specialists for ongoing care as so deter-
14 mined by the case manager in consultation with
15 the specialty care provider. This continuity of
16 care may be satisfied for enrollees with chronic
17 conditions through the use of a specialist serv-
18 ing as case manager.

19 “(3) ASSURING OUT-OF-NETWORK ACCESS.—

20 “(A) IN GENERAL.—An eligible organiza-
21 tion that contracts with a specific network of
22 providers must offer its enrollees or their treat-
23 ing provider with the patient's authorization
24 under this section, the ability at any time, to

1 seek items, services, and treatment from out-of-
2 network providers for all covered benefits.

3 “(B) REIMBURSEMENT FOR OUT-OF-NET-
4 WORK SERVICES.—An eligible organization
5 under this section shall provide for reimburse-
6 ment for the enrollee, consistent with the cost-
7 sharing schedule established under subpara-
8 graph (C), with respect to out-of-network serv-
9 ices which are described in subparagraph (A),
10 so long as the services were medically appro-
11 priate, and were covered benefits in-network.

12 “(C) ESTABLISHMENT OF COST-SHARING
13 SCHEDULE.—In consultation with the National
14 Association of Insurance Commissioners, the
15 Secretary shall establish (by not later than one
16 year after enactment of this Act) a cost-sharing
17 schedule which applies to payment required
18 under subparagraph (B) for out-of-network
19 services.

20 “(4) APPROPRIATE RANGE OF SERVICES.—A
21 health plan shall not deny any health care profes-
22 sionals, based solely on the license or certification as
23 applicable under State law, the ability to participate
24 in providing covered health care services, or be reim-
25 bursed or indemnified or by a network plan for pro-

1 viding such services. Organizations must ensure a
2 sufficient number, mix, and distribution of health
3 care professionals within a network plan to ensure
4 enrollees access to appropriate medical services.

5 “(5) GRIEVANCE AND APPEALS PROCESSES.—

6 “(A) GRIEVANCE PROCESS.—The organiza-
7 tion must provide meaningful procedures for
8 hearing and resolving grievances between the
9 organization (including any entity or individual
10 through which the organization provides health
11 care services) and members enrolled with the
12 organization under this section.

13 “(B) BOARD OF APPEALS.—

14 “(i) IN GENERAL.—Each eligible or-
15 ganization shall establish a board of ap-
16 peals to hear and make determinations on
17 complaints by enrollees concerning denials
18 of coverage or payment for services
19 (whether in-network or out-of-network)
20 and the medical necessity and appropriate-
21 ness of covered items and services.

22 “(ii) COMPOSITION.—A board of ap-
23 peals of an eligible organization shall con-
24 sist of—

1 “(I) representatives of the orga-
2 nization, including physicians,
3 nonphysicians, administrators, and
4 enrollees;

5 “(II) consumers who are not en-
6 rollees and those who have disenrolled;
7 and

8 “(III) providers with expertise in
9 the field of medicine which neces-
10 sitates treatment.

11 “(iii) DEADLINE FOR DECISION.—A
12 board of appeals shall hear and resolve
13 complaints within 30 days after the date
14 the complaint is filed with the board.

15 “(C) APPEAL TO SECRETARY.—A member
16 enrolled in an eligible organization under this
17 section who is dissatisfied with a determination
18 of a board of appeals of the organization under
19 subparagraph (B) is entitled, if the amount in
20 controversy is \$100 or more, to a hearing be-
21 fore the Secretary to the same extent as is pro-
22 vided in section 205(b), and in any such hear-
23 ing the Secretary shall make the eligible organi-
24 zation a party. If the amount in controversy is
25 \$1,000 or more, the individual or eligible orga-

1 nization shall, upon notifying the other party,
2 be entitled to judicial review of the Secretary's
3 final decision as provided in section 205(g), and
4 both the individual and the eligible organization
5 shall be entitled to be parties to that judicial re-
6 view. In applying sections 205(b) and 205(g) as
7 provided in this subparagraph, and in applying
8 section 205(l) thereto, any reference therein to
9 the Commissioner of Social Security or the So-
10 cial Security Administration shall be considered
11 a reference to the Secretary or the Department
12 of Health and Human Services, respectively.

13 “(6) NOTICE OF ENROLLEE RIGHTS AND
14 CONSUMER REPORT CARD.—

15 “(A) IN GENERAL.—Each eligible organi-
16 zation shall provide each enrollee, at the time of
17 enrollment and not less frequently than annu-
18 ally thereafter, an explanation of the enrollee's
19 rights under this section and a copy of the most
20 recent consumer report card for the organiza-
21 tion (as described in subparagraph (C)).

22 “(B) RIGHTS DESCRIBED.—The expla-
23 nation of rights under subparagraph (A) shall
24 include an explanation of—

1 “(i) the enrollee’s rights to benefits
2 from the organization;

3 “(ii) the restrictions on payments
4 under this title for services furnished other
5 than by or through the organization;

6 “(iii) out-of-area coverage provided by
7 the organization;

8 “(iv) the organization’s coverage of
9 emergency services and urgently needed
10 care;

11 “(v) the organization’s coverage of
12 out-of-network services, including services
13 that are additional to the items and serv-
14 ices covered under parts A and B; and

15 “(vi) appeal rights of enrollees.

16 “(C) CONSUMER REPORT CARD.—For pur-
17 poses of subparagraph (A), the term ‘consumer
18 report card’ means, with respect to an eligible
19 organization for a year, a report issued by the
20 organization which contains indicators of the
21 quality of the services under this section pro-
22 vided by the organization during the year. In-
23 formation must be provided in a manner that
24 permits consumers to compare organizations
25 with respect to the following:

1 “(i) For each plan, on—

2 “(I) the premium for the plan,

3 “(II) identity, location, qualifica-
4 tions, and availability of providers in
5 any provider networks of the plan,

6 “(III) the number of individuals
7 enrolling and disenrolling from the
8 plan,

9 “(IV) procedures used by the
10 plan to control utilization of services
11 and expenditures,

12 “(V) procedures used by the plan
13 to assure quality of care,

14 “(VI) the plan’s loss ratio, and

15 “(VII) rights and responsibilities
16 of enrollees.

17 “(ii) In addition, for each managed
18 care plan, on—

19 “(I) restrictions on payment for
20 services provided outside the plan’s
21 provider network,

22 “(II) the process by which serv-
23 ices may be obtained through the
24 plan’s provider network,

1 “(III) coverage for out-of-area
2 services, and

3 “(IV) any exclusions in the types
4 of providers participating in the plan’s
5 provider network.

6 “(7) RESTRICTIONS ON PROVIDER INCENTIVE
7 PLANS.—

8 “(A) IN GENERAL.—Each contract with an
9 eligible organization under this section shall
10 provide that the organization may not operate
11 any provider incentive plan (as defined in sub-
12 paragraph (B)) unless the following require-
13 ments are met:

14 “(i) No specific payment is made di-
15 rectly or indirectly under the plan to a pro-
16 vider or provider group as an inducement
17 to reduce or limit medically necessary serv-
18 ices provided with respect to a specific in-
19 dividual enrolled with the organization.

20 “(ii) If the plan places a provider or
21 provider group at substantial financial risk
22 (as determined by the Secretary) for serv-
23 ices not provided by the provider or pro-
24 vider group, the organization—

1 “(I) provides stop-loss protection
2 for the provider or group that is ade-
3 quate and appropriate, based on
4 standards developed by the Secretary
5 that take into account the number
6 (and type) of providers placed at such
7 substantial financial risk in the group
8 or under the plan and the number of
9 individuals enrolled with the organiza-
10 tion who receive services from the pro-
11 vider or the group, and

12 “(II) conducts periodic surveys of
13 both individuals enrolled and individ-
14 uals previously enrolled with the orga-
15 nization to determine the degree of
16 access of such individuals to services
17 provided by the organization and sat-
18 isfaction with the quality of such serv-
19 ices.

20 “(iii) The organization provides the
21 Secretary with descriptive information re-
22 garding the plan, sufficient to permit the
23 Secretary to determine whether the plan is
24 in compliance with the requirements of this
25 subparagraph.

1 “(B) PROVIDER INCENTIVE PLAN DE-
2 FINED.—In this paragraph, the term ‘provider
3 incentive plan’ means any compensation ar-
4 rangement between an eligible organization and
5 a provider or provider group that may directly
6 or indirectly have the effect of reducing or lim-
7 iting services provided with respect to individ-
8 uals enrolled with the organization.

9 “(8) ADDITIONAL DEFINITIONS.—

10 “(A) IN-NETWORK.—The term ‘in-network’
11 means services provided by health care provid-
12 ers who have entered into a contract or agree-
13 ment with the organization under which such
14 providers are obligated to provide items, treat-
15 ment, and services under this section to individ-
16 uals enrolled with the organization under this
17 section.

18 “(B) NETWORK.—The term ‘network’
19 means, with respect to an eligible organization,
20 the health care providers who have entered into
21 a contract or agreement with the organization
22 under which such providers are obligated to
23 provide items, treatment, and services under
24 this section to individuals enrolled with the or-
25 ganization under this section.

1 “(C) OUT-OF-NETWORK.—The term ‘out-
2 of-network’ means services provided by health
3 care providers who have not entered into a con-
4 tract agreement with the organization under
5 which such providers are obligated to provide
6 items, treatment, and services under this sec-
7 tion to individuals enrolled with the organiza-
8 tion under this section.”.

9 (b) CONFORMING AMENDMENTS.—Section 1876 of
10 such Act is further amended—

11 (1) by striking subparagraph (E) of subsection
12 (c)(3);

13 (2) by striking paragraphs (4) and (5) of sub-
14 section (c); and

15 (3) by striking paragraph (8) of subsection (i).

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to contract years beginning at least
18 60 days after the date the Secretary establishes the cost-
19 sharing schedule for out-of-network services under section
20 1876(k)(2)(C) of the Social Security Act (as added by sub-
21 section (a)(2)).

22 **SEC. 4. APPLICATION OF PROTECTIONS TO MEDICARE SE-**
23 **LECT POLICIES.**

24 (a) IN GENERAL.—Section 1882(t)(1) of the Social
25 Security Act (42 U.S.C. 1395ss(t)(1)) is amended—

1 (1) by striking “and” at the end of subpara-
2 graph (E);

3 (2) by striking the period at the end of sub-
4 paragraph (F) and inserting a semicolon; and

5 (3) by adding at the end the following new sub-
6 paragraph:

7 “(G) notwithstanding any other provision
8 of this section to the contrary, if the issuer of
9 the policy—

10 “(i) meets the requirements of section
11 1876(k) with respect to individuals en-
12 rolled under the policy in the same manner
13 such requirements apply with respect to an
14 eligible organization under such section
15 with respect to individuals enrolled with
16 the organization under such section, and

17 “(ii) discloses (in a form and manner
18 specified by the Secretary) the loss ratio
19 described in subsection (r)(1) most re-
20 cently calculated for purposes of such sub-
21 section.”.

22 (b) EFFECTIVE DATE.—The amendments made by
23 subsection (a) shall apply to policies issued or renewed on
24 or after the effective date described in section 3(c).

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